Annapolis Periodontics

COVID-19 Patient Screening Form

Please print and take with you to your appointment.

Patient Name: **Date:**

	CIRCLE ANSWER	
Do you have a fever or felt hot/feverish recently (past 14-21 days)?	**YES**	**NO**
Are you having shortness of breath or difficulty breathing?	**YES**	**NO**
Do you have a cough?	**YES**	**NO**
Do you have flu-like symptoms/GI upset/headache/fatigue?	**YES**	**NO**
Have you experienced recent loss of taste or smell?	**YES**	**NO**
Are you in contact with any confirmed COVID-19 positive people?	**YES**	**NO**
Are you over 60 years of age?	**YES**	**NO**
Do you have heart disease, lung disease, kidney disease, Diabetes, or any auto-immune disease?	**YES**	**NO**

Positive responses would indicate a discussion with doctor

TEMPERATURE _____________(will be taken upon entering the office)

Taken by:____________________